

Jackson County Medication Assisted Treatment Diversion Program

Courthouse, 307 Main Street Black River Falls, WI 54615

Defendant Request and Consent to Participate in Diversion Program

Defendant Name: _____
(Print Full Name)

Case Number: _____ Date: _____

Charge(s): *[Check if felony or misdemeanor and list current charge(s)]*

Felony _____

Misdemeanor _____

[Have defendant read and initial each item listed below and sign and date.]

_____ I am requesting and understand that I am being considered for diversion into a Medication Assisted Treatment program, as I may qualify.

_____ I understand that in order to qualify for diversion, I must meet certain legal and clinical criteria, and that there is no right to acceptance, nor guarantee that I will be accepted.

_____ I understand that the diversion is voluntary and that I may choose at any time during the assessment process to decline and have my case proceed on the regular criminal docket.

_____ I am a resident of Jackson County, Wisconsin.

_____ I understand that, while I am being considered for diversion, my criminal case will continue, I must continue to make all scheduled criminal or other court appearances, and that a warrant for my arrest will be issued if I fail to attend hearings.

_____ I agree to cooperate in the intake and assessment process, including filling out forms and providing releases so that the diversion program can obtain relevant information about me, including medical, mental health, and substance abuse treatment information.

_____ I understand that the clinical information that is gathered in the diversion intake process will NOT be used against me if my case remains on or is returned to the regular criminal docket.

_____ I understand that if my case is accepted into the diversion program, I may be required to:

- Submit to random urinalysis testing;
- Maintain a residence;
- Apply for local, state and/or federal entitlement programs;
- Agree to fulfill other conditions as may be required by the District Attorney.

_____ I understand that if my case is accepted in to diversion program, I will be required to:

- Agree that my right to speedy trial will be tolled while I continue in the program and otherwise waive having my case heard with applicable time limits;
- Fulfill a Treatment/Intervention Plan of up to one year in duration.
- Not commit any new crimes;

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- Not possess weapons;
- Not consume alcohol, illicit drugs, or any other non-prescribed drugs.

_____ I understand that if I am accepted into the diversion program, any treatment and services provided to me to fulfill requirements of my Treatment/Intervention Plan may be billed by the provider to my insurance, Medicaid, or any other sources of payment including directly to me.

_____ I understand that information about my case may be used for statistical purposes to evaluate the Diversion program.

_____ I understand that if I successfully complete the requirements of the diversion program, either my charges will be dismissed or my sentence reduced.

Defendant's Signature

Date

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